COUNTY OF LOS ANGELES
DEPARTMENT OF MENTAL HEALTH

CLIENT FACE SHEET

CONFIDENTIAL CLIENT INFORMATION SEE CALIFORNIA WELFARE AND INSTITUTION CODE 5328

CLIENT DATA			CLIENT I.D.#
Last Name:			
First Name:		Middle Name:	
AKA/Maiden Last Name:			
AKA/Maiden First Name:		Middle Name:	
SSN:	Mother's Maiden Name:		
Gender: Male: ☐ Female: ☐ Other: ☐ Unknown: ☐		DOB:	Age:
English Speaking: Yes ☐ No ☐	Primary Lang:	Preferred Lang:	
Ethnicity:	If Hispanic, Indicate Origin:	If American Indian/Alaska Native, Indicate Tribe:	
Education Level :	Level of Care:	Conservatorship:	
Handicap:	Marital Status:	APR:	Veteran: Yes ☐ No ☐
Living Arrangement:	Employment Status:	DOD:_____	

CLIENT ADDRESS			
Transient/Homeless:	Time Homeless:		
Address:			
Second Line:			
City:	State:	Zip:	County:
Phone:	(Home)	(Business)	
Address Memo:			

EMERGENCY CONTACTS			**DO NOT CONTACT** ☐
Name:		Contact Type:	
Address:	City:	State:	Zip:
Relationship:	Phone:	Email:	
Name:		Contact Type:	
Address:	City:	State:	Zip:
Relationship:	Phone:	Email:	

Complete only if the Client's Child is enrolled in FSP			
Name:		Contact Type: **Child Enrolled in FSP**	
Address:	City:	State:	Zip:
DMH I.D.#	Phone:	Email:	

SFPR	
Rendering Provider/Team ID:	Provider Number:

BIRTH INFORMATION		
Indicate Client Birth Name (If different than the name above in Client Data)		
Last Name:	First Name:	Middle Name:
Birth County:	Birth State:	Birth Country (If born outside US):
Mother's First Name:		

Provider Name:_____ Provider Number:_____